DIVISION OF MEDICAL SERVICES
PROVIDER BULLETIN

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PSYCHOTHERAPY BULLETIN
PHYSICIAN (PSYCHIATRIST), PSYCHOLOGIST, PCNS, LCSW, LPC, FQHC, RHC

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PRIOR AUTHORIZATION FOR PSYCHOLOGICAL SERVICES FOR ADULTS

The Prior Authorization (PA) process for Psychological Services (13 CSR 70-98.020) serves as a utilization management measure allowing payment for treatment and services (interventions) that are medically necessary, clinically appropriate and cost-effective without compromising the quality of care to Missouri Medicaid recipients. The PA process for Psychological Services for adults was implemented on November 1, 2004.

DIAGNOSIS CODES AND AUTHORIZED HOURS FOR ADULTS

Effective January 1, 2006 authorizations for Individual or Family Therapy will be issued for up to twenty (20) hours of therapy based upon provider request for all covered diagnosis codes not including Adjustment Disorder, V code, or an NOS (not otherwise stated) Diagnostic and Statistical Manual-IV-Text Revision (DSM-IV-TR) diagnosis code. The twenty (20) hours may be divided between Individual and Family Therapy based upon provider request, recipient need and, documentation in the Treatment Plan. The intent is to limit the first PA to no more than twenty (20) hours of Individual or Family Therapy in any combination for any recipient regardless of provider.

PA for diagnosis codes involving Adjustment Disorder, V code, or an NOS code may be issued for up to ten (10) hours of Individual or Family Therapy or a combination of both. The intent is to limit any PA to ten (10) hours of Individual or Family Therapy or a combination of the two for these diagnosis codes for any recipient regardless of provider.

Effective January 1, 2006 PAs for Group Therapy will be issued for up to twenty (20) hours based on provider request for all covered diagnosis codes not including Adjustment Disorder, V code, or an NOS DSM-IV-TR diagnosis code. PAs will be issued for up to ten (10) hours if the covered diagnosis code involves an Adjustment disorder, V code, or an NOS DSM-IV-TR diagnosis code. This therapy may be requested in addition to the Individual and Family request outlined above based upon recipient need and documentation in the Treatment Plan. The intent is to limit the first PA to no more than twenty (20) hours of Group Therapy for any recipient regardless of provider.

An additional ten (10) hours of Individual, Family or Group Therapy or any combination may be requested based upon documentation of recipient need. PAs for Continued Treatment (authorizations beyond the initial twenty (20) hours of Individual, Family and/or Group Therapy) will be based upon review of clinical documentation to include:

- Psychological Services Request for Prior Authorization form
- Current Diagnostic Assessment
- Current/Updated Treatment Plan
- Three Progress Notes reflective of therapy type requested (i.e. requests for additional family therapy should include, progress notes from the three most recent family therapy sessions attended by the recipient)

All documentation submitted must meet the requirements as stated in 13 CSR 70-98.015 <http://www.sos.mo.gov/adrules/csr/current/13csr/13c70-98.pdf> and must be current as of the date of the request. PAs for Continued Treatment will **not** be issued for diagnosis codes including Adjustment Disorder, V code, or an NOS DSM-IV-TR diagnosis code. Requests submitted with non-compliant documentation as outlined above, will result in denial of the request.

IN ORDER TO FACILITATE THIS POLICY, ALL PAs FOR ADULT PSYCHOLOGICAL SERVICES WILL BE CLOSED EFFECTIVE DECEMBER 31, 2005.

PROVIDERS MAY REQUEST A PA FOR ADULTS ACCORDING TO THE GUIDELINES DESCRIBED ABOVE FOR SERVICES TO BE DELIVERED AFTER DECEMER 31, 2005.

DOCUMENTATION MUST BE MAINTAINED IN THE RECIPIENT'S MEDICAL RECORD; HOWEVER THIS DOCUMENTATION IS NOT REQUIRED TO BE SUBMITTED FOR AN ADULT INITIAL REQUEST AFTER JANUARY 1, 2006. INITIAL REQUESTS FOR ADULTS MAY BE MADE BY PHONE.

CLINICAL EXCEPTIONS FOR ADULTS

The Division of Medical Services recognizes that there are rare instances in which psychological services may be authorized beyond the limits outlined above. For those persons who require more than the thirty (30) hours of Individual, Family or Group Therapy per year, as discussed above, Clinical Exceptions may be granted based upon documentation of extenuating circumstances.

NON-PRIOR AUTHORIZED HOURS

Providers may deliver four (4) hours of Psychological Services without prior authorization to a recipient they have not provided treatment to within the last rolling year. The 4 hours are intended to assist a provider seeing a recipient for the first time in making the transition to PA should more than four (4) hours be required for treatment. The claims for the four (4) non-Prior Authorized hours should be submitted and payment received prior to submitting **claims** for any Prior Authorized hours/services. Providers who have been paid for services in excess of four (4) hours for a recipient in the last year will not receive four (4) non-Prior Authorized hours for that recipient. Family Therapy without the Patient Present, Individual Interactive Therapy and all psychological services for recipients age 0-2 years are not included in the four (4) Non-Prior Authorized hours and continue to require PA.

INITIATION OF THE PRIOR AUTHORIZATION PROCESS FOR ADULTS

If services are required beyond the initial four (4) Non-Prior Authorized hours, the provider must request a prior authorization. Providers may make their request via phone, fax, or mail. The Psychological Services Request for Prior Authorization Form must be used when requesting a PA by mail or by fax. Please see attachment to the May 27, 2005 bulletin, Volume 27, Number 20. If requesting Continued Treatment the Psychological Services Request for Prior Authorization Form must be mailed or faxed and accompanied by the:

- Current Diagnostic Assessment
- Current/Updated Treatment Plan
- Three Progress Notes reflective of therapy type requested (i.e. requests for additional family therapy should include, progress notes from the three most recent family therapy sessions attended by the recipient).

When requesting the initial PA by telephone, the form need not be used but all information on the form must be readily available to the caller.

Requests may be made as follows:

Mail: Division of Medical Services
P.O. Box 4800
Jefferson City, MO 65102
Or
Phone: 866-771-3350
Or
Fax: 573-635-6516

Before requesting additional hours, 75% of the current PA hours must be used. Hours used must be documented in the medical record. The PA approves the delivery of the requested service only and does not guarantee payment. The PA *must* be obtained prior to delivery of services. The recipient must meet eligibility requirements on the date the service is provided and the provider must be enrolled and eligible to bill for the services.

PSYCHOLOGICAL DIAGNOSIS CODING

Psychological services will be authorized if they are determined medically necessary when using the DSM-IV-TR diagnosis criteria. In order to remain compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) the appropriate International Classification of Diseases 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code must be used when filing a claim for the service.

Claims for psychotherapy procedures require one of the following diagnosis codes in order to be considered for payment: 295-316, V11-V11.8, V15.4-V15.42, V17-V17.0, V40-V40.1, V61-V61.9, V62.4, V62.8-V62.89, V67.3, V71.0-V71.02 and V79-V79.1. Providers must use the appropriate 4th and 5th digits when applicable. These codes are listed in the current ICD-9-CM. Psychotherapy services are not covered for primary diagnoses 317, 318 and 319 related to mental retardation.

REMOVAL OF DIAGNOSTIC ASSESSMENT AND TESTING

Procedure codes for Diagnostic Assessment and Testing have been removed from the PA process. These codes remain subject to Medicaid program restrictions and limitations. Currently Diagnostic Assessment is limited to six (6) units or three (3) hours per provider per recipient per rolling year. Currently Testing is limited to four (4) hours/units per provider per recipient per rolling year. Recipients under the age of three (3) require PA for **ALL** Psychological Services including diagnostic Assessment and Testing. Provider type/provider specialty restrictions remain the same.

PRIOR AUTHORIZATION EXEMPTIONS

Procedure codes with an evaluation and management component are exempt from prior authorization.

Crisis intervention, when provided by a psychiatrist, psychologist, psychiatric clinical nurse specialist (PCNS), licensed clinical social worker, (LCSW), provisionally licensed clinical social worker (PLCSW), licensed professional counselor (LPC), provisionally licensed professional counselor (PLPC), rural health clinic (RHC), federally qualified health center (FQHC), or inpatient hospital, are exempt from the prior authorization process. The definition of crisis intervention is: “the situation must be of significant severity to pose a threat to the patient’s well being or is a danger to self or others”. Crisis intervention services cannot be scheduled nor can they be prior authorized. Crisis intervention services are limited to six (6) 60-minute units per provider per recipient per rolling year.

RECIPIENT APPEAL RIGHTS

For PA requests denied in part or in full, the recipient will receive a letter outlining the reason for denial and their appeal rights.

Note: Providers should not give recipients the provider Prior Authorization Request telephone number or fax number. Contact information will be listed in their denial letter.

Provider Bulletins are available on the DMS Website at http://www.dss.mo.gov/dms/pages/bulletins.htm. Bulletins will remain on the Published Bulletin site only until incorporated into the provider manuals as appropriate, then moved to the Archived Bulletin site.

Missouri Medicaid News: Providers and other interested parties are urged to go to the DMS Website at http://dss.missouri.gov/dms/subscribe/MedNewsSubscribe.htm to subscribe to the list serve to receive automatic notifications of provider bulletins, provider manual updates, and other official Missouri Medicaid communications via e-mail.

MC+ Managed Care: The information contained in this bulletin applies to coverage for:

- MC+ Fee-for-Service
- Medicaid Fee-for-Service
- Services not included in MC+ Managed Care

Questions regarding MC+ Managed Care benefits should be directed to the patient's MC+ Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MC+ card or by calling the Interactive Voice Response (IVR) System at 1-573-635-8908 and using Option One.

Provider Communications Hotline
573-751-2896